

University Honors Capstone Project

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11/22/16

**NORTHERN ILLINOIS UNIVERSITY**

Sexual Education: Abstinence-Only vs. Comprehensive Education

**A Thesis Submitted to the**

**University Honors Program**

**In Partial Fulfillment of the**

**Requirements of the Baccalaureate Degree**

**With Upper Division Honors**

**Department Of**

Nursing

**By**

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**DeKalb, Illinois**

December, 2016

University Honors Program

Capstone Approval Page

Capstone Title:

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Sexual Education: Abstinence-Only vs.  
Comprehensive Education

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Department of: Nursing

Date of Approval: 11/22/16

**HONORS THESIS ABSTRACT  
THESIS SUBMISSION FORM**

AUTHOR: Alex Filippini

THESIS TITLE: Sexual Education: Abstinence-Only vs. Comprehensive Education

ADVISOR: Dr. Mary Elaine Koren

ADVISOR'S DEPARTMENT: Nursing

DISCIPLINE: Nursing

YEAR: 2016

PAGE LENGTH: 14 (including title page, abstract, and bibliography)

BIBLIOGRAPHY: See references section (page: 16)

ILLUSTRATED: N/A

PUBLISHED (YES OR NO): No

LIST PUBLICATION: N/A

COPIES AVAILABLE: Hard Copy and Digital Copy

ABSTRACT: See abstract section (page: 6)

Sexual Education: Abstinence-Only vs. Comprehensive Education

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### Abstract

This paper aims to discuss the differences between abstinence-only sexual education and comprehensive sexual education. Both are methods of teaching children, generally from middle school age through high school, about sex and development; however, one focuses on saving sex for marriage (abstinence), while the other teaches this concept along with methods for contraception and sexually transmitted infection prevention (comprehensive). By discussing the background of sexual education in the United States (US), the curriculum in both the United States (US) and European countries (the Netherlands, Sweden, Germany, and France), and methods for improving US sexual education, this paper will discuss the benefits and downfalls of both abstinence-only and comprehensive sexual education to illustrate what needs to be changed to improve US curriculum.

### Sexual Education: Abstinence-Only vs. Comprehensive Education

Sexual Education, usually referred to as Sex Ed, is curriculum taught in schools in the US and in schools throughout the world. It is, in theory, curriculum designed to teach children about their developing bodies and sexual urges that they may begin to feel. In the US, this curriculum aligns with the established onset of puberty and often begins in middle school and continues throughout high school. This practice however, is controversial in that there is a difference in opinion regarding the method in which these programs are taught – abstinence-only vs comprehensive sexual education.

This conflict in teaching is doing nothing to benefit the teenagers taught this curriculum. At a rate of 24.2 per 1000 women, the US, has the higher number of births to women between the ages of 15-19 years old when compared to European counterparts. For example, when looking at the birth rates in the Netherlands (1.3 per 1000 women), Sweden (1.5 per 1000 women), Germany (3.6 per 1000 women), and France (4.4 per 1000 women) it is clear that there is a large difference between Europe and the US (About, 2016; UK, 2016). The question is why?

This paper aims to explain the differences between, and downfalls of, abstinence-only education when compared to the comprehensive method. It will also examine the differences in curriculum, and associated outcomes, of the Netherlands, Sweden, France, and Germany when compared to the US.

### **Background**

Abstinence-only education is a conservative method of teaching teenagers about their sexuality. It emphasizes that all types of sexual activity should be avoided until marriage and states that abstinence is the only guaranteed, effective method for preventing pregnancy and

sexually transmitted infections (STIs). Other forms of birth control are rarely mentioned and, if taught, failure rates are emphasized. Abstinence-only teaching generally relies on fear tactics instead of focusing on the realities of teenage sexual activity. On the other hand, comprehensive sexual education includes abstinence teaching but, recognizes that abstinence until marriage may not be the most realistic goal. Other methods of contraception are taught and information is given regarding STIs, sexual development, and relationships as well (Caldwell, 2015). However, the type of sexual education most often taught in the US is abstinence-only.

In 1981 the Adolescent Family Life Act passed through the US Congress. This act encouraged US public schools to start teaching abstinence-only in hopes of reducing rates of teenage pregnancy and STIs. In 1998 the federal government passed Title V which continued this trend. Fifty million dollars was sanctioned for implementing abstinence-only programs in schools in the US. This funding was expanded upon in 2001, and by 2011, 27 states required that abstinence be taught in their schools (Bell, 2009; Kimmel, Williams, Veinot, Campbell, Campbell, & Kruger, 2013). Five years later, things have yet to improve. All states now have some sort of mandate requiring sex ed be taught in public schools, however, there is no clear method as to how it should be taught. As of March 1 of this year, 33 states and the District of Columbia (DC) require that children receive information about HIV, 24 states and the DC require that public schools teach some form of sex ed, and only 20 states require that sex ed/HIV education be medically accurate. If not all states require medical accuracy, then just what are they teaching students in the US (National, 2016)?

### **Curriculum: United States**

In the author's high school, a comprehensive approach is taken regarding sex ed. While classes are not taught by the school nurse, two of the gym teachers are designated to teach Health



Class; a unit of which covers reproduction, relationships, and STIs. Abstinence is mentioned and is described as the only 100% effective way in preventing physical, social, mental, and emotional consequences of engaging in sexual activity. It is also explained that abstinence is the safest and healthiest lifestyle choice. Contraception is covered but, not much information is given. Different methods (intrauterine devices, condoms, oral contraceptives, etc) are pictured and a graph is presented showing their rates of effectiveness (Beerbower, 2016a; Beerbower, 2016b; Beerbower, 2016c).

Though information about contraception could be a little more in depth, research shows that this type of comprehensive sexual education can decrease the amount of unintended pregnancies and STIs and can even delay the timing of first sexual experiences. Lindberg and Maddow-Zimet (2012) surveyed 15-24-year-olds regarding topics addressed in their formal sexual education (age of first sexual experience, contraceptive use, STI prevention, and healthy relationship development). This study determined that those who received information on delaying sex and types of birth control were more likely to have healthy sexual behaviors at the time they chose to first engage in sexual activity than those who did not receive comprehensive education. Receipt of comprehensive sexual education was shown to have a positive correlation with later age of first sexual experience, greater use of contraception at time of first sex, and healthier relationship with first sexual partner. Kohler, Manhart, and Lafferty (2008) surveyed a total of 1719 unmarried heterosexual adolescents and found similar results. Those who received comprehensive sexual education were at reduced risk of unwanted teen pregnancy, contraction of STIs, and were shown to delay the time of first sex when compared to those who received abstinence-only or no formal sexual education.

While this evidence may be pertinent, the fact remains that favor is still held by the abstinence-only method. While more progressive parents feel that it is necessary to teach kids about safe sex and contraception, proponents of the abstinence-only method, like conservative parents and politicians, believe that comprehensive sex ed is confusing for students. Why would they need to know about contraception when they are supposed to be waiting until marriage to have sex? The goal of delivering a constant message of abstinence remains and children who choose to have sex are left with no practical knowledge on how to do so safely (Caldwell, 2015).

### **Curriculum: Europe**

Sexual education is far less of a controversy in European countries than it is in the US. Countries like the Netherlands, Sweden, Germany and France take on a sex positive approach in teaching sex ed. Teenage sexual development is seen as a normal and healthy part of life which is a stark contrast when compared to the US that views it as taboo. This section provides an overview to the methods used to teach sexual education in the countries mentioned above.

In the Netherlands, Dutch parents anticipate that their children will begin to form relationships in their teen years and aim to ensure that they have the appropriate information to engage in sex safely. Sex ed in the Netherlands became mandatory, by law, in 1993 and is required to provide students with information on sexual development, pregnancy, STIs sexual orientation, homophobia, respect for others and their views on sex, and skills for developing healthy sexual relationships. All teachers are specially trained in giving sexual education and curriculum is designed to encourage open discussion about sexuality and related issues. Sessions are usually directed by student questions and no topic is considered off limits. The main goal of Dutch sex ed is to empower teens to make good choices regarding their sexual health and to set their own boundaries as to what they are comfortable with sexually. Outside of school based

education, information is provided to parents, clinics, family doctors, and the media to help further influence teenagers to make healthy decisions (Bell, 2009).

Sexual education in Sweden has been mandatory since 1955. All teachers are specially trained in sexual education techniques and curriculum starts as early as preschool. Swedish sexual education has four key principles: no person should be used as a means for another person's own sexual gratification, no one should ever be coerced into having sex with another person, the most satisfying sexual relationships stem from healthy personal relationship but, those who partake in casual sex should not be considered immoral, and finally, it is a duty to be loyal in a personal relationship both sexually and otherwise. The main goal of Swedish sexual education is to provide honest answers to teens about sex and to promote responsibility and respect between those who choose to engage in sexual activity. Sweden also has a host of clinics run by midwives, gynecologists, and social health workers specifically to help teens get access to reproductive healthcare. These clinics even provide affordable versions of contraception and abortions without need of parental consent (Bell, 2009; Weale, 2015).

German sex ed is treated as a partnership between the government, schools, community-based organizations, and health authorities. Programs must be comprehensive and based on developmental age. Sex ed is not just taught through the middle school and high school years but, throughout the duration of a child's education from beginning to end. The goals of German sexual education are to teach students not only about anatomical sexual development and STIs but to teach about individual sexual development, personal identity, gender roles, relationships, pregnancy, and other sexual lifestyles like those of gay, lesbian, and transgender people. German sex ed is all about tolerance, using protection, and making responsible sexual decisions. In addition to this sex positive method of teaching, Germany provides free oral contraceptives,

intrauterine devices (IUDs), barrier methods (male/female condoms), and sterilization (tubal ligations – tying off/cauterization of fallopian tubes) to women under 20 years of age. For women above 20 years of age, all of these services are covered by insurance as well as abortion which is legal in the first trimester of pregnancy. Condoms are also easily accessible in grocery stores, restaurants, pharmacies, night clubs, and vending machines in public restrooms (Bell, 2009; Brockschmidt & Hessling 2015).

As of 1996 all French schools are required to devote at least two hours to sexual education for students ages 12-14. The law also applies to students over age 13 who are required to receive 20-40 hours of sexual education over a four-year period. Programs are usually student lead in the sense that their questions determine areas of interest to be taught in the curriculum. Curriculum is generally focused on sexual development, reproduction, STIs and contraception. Anatomy is taught by biology teachers and specialists are invited to come in and teach lessons in their areas of expertise. In France, condoms and contraception are offered free to teens and national health insurance covers reproductive health for those under the age of 18. Abortions are also free through week ten of pregnancy. In France, schools, the media, and the community all work as a team to encourage healthy teenage sexual behavior (Bell, 2009; Henderson, 2012).

### **Methods for Improvement**

When comparing Europe and the US it is easy to see that there are vast differences in the ways sexual education is taught. Simply comparing the birth rates of teenage women in the US (24.2 per 1000 women) and the Netherlands (1.3 per 1000 women) alone can indicate what is effective in regard to teaching kids about their bodies and their development (About, 2016; UK, 2016). The real problem is that the US as whole is resistant to the fact that teenagers have sex and that they can do so safely. What really needs to change in the United States is the culture.

Kimmel, Williams, Veinot, Campbell, Campbell, and Valacak (2013), gathered opinions of sexual education in the United States from a group of African American students. The results of this study created a picture of US sexual education as uncomfortable, awkward, and unsafe to ask questions. Teachers were often uncomfortable with the content and reluctant to explain to their students the very content the class was designed to teach them. This same study also proposed a solution to this problem. The African Americans questioned believed that much of the sex ed programs could be made better if medical professionals were the ones to teach them. Almost every school has a nurse, it doesn't make sense if their expertise is not utilized in this area. If the problem with the curriculum is the fact that the teacher is too uncomfortable to teach it, then someone, like the school nurse, should step in to make sure that the students get the information they need.

Another problem with the United States' method in teaching sexual education is that it is started too late. Sex ed is started as early as age four in the Netherlands and covers much more than simple reproduction. Their focus is sexuality, not just sex, and they teach children of all ages about relationships and intimacy. Aside from their method of instruction, the only real difference between the sexual activity of teenagers in the Netherlands and those in the US is that their experiences with first sex are "wanted and fun" instead of full of confusion and regret (DeMelker, 2015).

This idea is in stark contrast to what is currently happening in the United States. Conservative American parents are so devoted to preserving their children's innocence that they sometimes go to the extent of having their daughters pledge purity to them. A purity ball is an occasion on which girls as young as five attend a party with their fathers. They dance, they eat, and they celebrate just like any other father-daughter dance. However, at the end, the girls must

vow that they will remain chaste until marriage. This is an awfully big promise for a five-year-old, who most likely does not even know what chaste means. Parents in the United States are so scared that their children will become pregnant that instead of teaching them about safe sex, they will place responsibility, sometimes solely on their daughters, to remain “pure” until marriage. No matter how many vows a child may make to remain pure, there is still a chance he or she will have sex before marriage. Wouldn't it be better if he or she knew how to do so safely (Weisman, 2015)?

The problem doesn't stop there, even researchers are still trying to determine the validity of abstinence-only education and promote it in public schools in the US. Bailey and Wolf (2015) conducted a study of middle school students. Their goal was to educate 500 or more students about the physiological and psychological benefits of abstinence, to involve caregivers and parents to improve family communication, and to give information to professional groups and the surrounding population about the benefits of waiting for sex until marriage. While they did have some of the right ideas regarding sexual education – like including medical professionals, and handing out resources to parents and local clinics - their teaching was ineffective as it was abstinence-based. Students and parents were surveyed over the course of the three year period and while parents appreciated receiving information regarding sexual education and support in teaching their children about abstinence, students were not receptive to the abstinence-only method of teaching. Most students deemed it unrealistic to expect them to wait until marriage to have sex.

### **Conclusion**

The United States, as a whole, could benefit from a change in the perception of teenage sexuality. Now, it might be unrealistic to expect an entire nation to adopt a sex positive outlook

overnight but, at the very least, sex ed programs should take a turn for the comprehensive route. It is clear abstinence-only education is not working and that purity vows cannot stop a natural part of development from taking place. The United States should look toward European nations for inspiration and guidance when it comes to sexual education. Laws should be changed to ensure that kids have access to information, healthcare, and contraception when it comes to safe sex practices. Most importantly, programs designed to teach kids about sex and intimacy should be implemented in a way that they will have the most positive impact. Teachers should be trained to teach this topic, the program should assess the needs of the individuals taught, goals should be clearly set, and students should feel safe enough in the environment to ask questions and learn about their sexuality (Kirby, Laris, & Rolleri, 2007). The only real way to make progress and to prevent pregnancy and STIs is to educate on prevention. Abstinence-only education has been proven unrealistic countless times and no one should be deprived of knowledge that can keep them safe and healthy, sexually and otherwise.

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